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the Act that pertains to cost-sharing in enrollment-related costs. It sets forth the procedures that HCFA follows to assess the required fees on M+C plans offered by M+C organizations.

- (b) Purpose of assessment. Section 1857(e)(2) of the Act authorizes HCFA to charge and collect from each M+C plan offered by an M+C organization its pro rata share of fees for administering section 1851 of the Act, relating to dissemination of enrollment information; and section 4360 of the Omnibus Budget Reconciliation Act of 1990, relating to the health insurance counseling and assistance program.
- (c) Applicability. The fee assessment also applies to those demonstrations for which enrollment is effected or coordinated under section 1851 of the Act.
- (d) Collection of fees—(1) Timing of collection. HCFA collects the fees over nine consecutive months beginning with January of each fiscal year.
- (2) Amount to be collected. The aggregate amount of fees for a fiscal year is the lesser of the following:
- (i) The estimated costs to be incurred by HCFA in that fiscal year to carry out the activities described in paragraph (b) of this section.
- (ii) The amount authorized in the DHHS appropriation for the fiscal year.
- (e) Assessment methodology. (1) The amount assessed is a percentage of the total Medicare payments to each organization. HCFA determines the percentage rate using the following formula:

A times B divided by C where-

A is the total of the estimated January payments to all organizations subject to assessment;

B is the nine-month (January through September) assessment period; and

C is the total assessment amount authorized for the particular fiscal year in accordance with paragraph (d)(2) of this section.

(2) HCFA determines each organization's pro rata share of the annual fee on the basis of that organization's calculated monthly payment amount during the nine consecutive months beginning with January. HCFA calculates each organization's monthly pro rata share by multiplying the established percentage rate by the total monthly calculated Medicare payment amount to the organization as recorded in

HCFA's payment system on the first day of the month.

- (3) HCFA deducts the organization's fee from the amount of Federal funds otherwise payable to the organization for that month under the M+C program.
- (4) If assessments reach the amount authorized for the year before the end of September, HCFA discontinues assessment.
- (5) If there are delays in determining the amount of the annual aggregate fees specified in paragraph (d)(2) of this section or the fee percentage rate specified in paragraph (e), HCFA may adjust the assessment time period and the fee percentage amount.

Subpart B—Eligibility, Election, and Enrollment

SOURCE: 63 FR 35071, June 26, 1998, unless otherwise noted.

§ 422.50 Eligibility to elect an M+C plan.

- (a) An individual is eligible to elect an M+C plan if he or she—
- (1) Is entitled to Medicare under Part A and enrolled in Part B (except that an individual entitled only to Part B and who is (or was) enrolled in an HMO or CMP with a risk contract under part 417 of this chapter on December 31, 1998 may continue to be enrolled in the M+C organization as an M+C plan enrollee);
- (2) Has not been medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in an M+C plan or in a health plan offered by the M+C organization offering an M+C plan in the service area or continuation area in which the individual resides may continue to be enrolled in the M+C organization as an M+C plan enrollee;
- (3) Resides in the service area of the plan, except that an individual who resides in a continuation area of an M+C plan while enrolled in a health plan offered by the M+C organization may continue to be enrolled in the M+C organization as an M+C plan enrollee;
- (4) Completes and signs an election form and gives information required for enrollment; and

- (5) Agrees to abide by the rules of the M+C organization after they are disclosed to him or her in connection with the election process.
- (b) An M+C eligible individual may not be enrolled in more than one M+C plan at any given time.

[63 FR 35071, June 26, 1998; 63 FR 52611, Oct. 1, 1998]

§ 422.54 Continuation of enrollment.

- (a) Definition. Continuation area means an additional area (outside the service area) within which the M+C organization furnishes or arranges for furnishing services to its continuation-of-enrollment enrollees. Enrollees must reside in a continuation area on a permanent basis. A continuation area does not expand the service area of any plan.
- (b) Basis rule. An M+C organization may offer a continuation of enrollment option to enrollees when they no longer reside in the service area of a plan and permanently move into the geographic area designated by the M+C organization as a continuation of enrollment area. The intent to no longer reside in an area and permanently live in another area is verified through documentation that establishes residency, such as, driver's license, voter registration.
- (c) General requirements. (1) An M+C organization that wishes to offer a continuation of enrollment option must meet the following requirements:
- (i) Obtain HCFA's approval of the continuation area, the marketing materials that describe the option, and the M+C organization's assurances of access to services.
- (ii) Describe the option(s) in the member materials it offers and make the option available to all enrollees residing in the continuation area.
- (2) An enrollee who moves out of the service area and into the geographic area designated as the continuation area has the choice of continuing enrollment or disenrolling from the plan.
- (d) Specific requirements—(1) Basic benefits. The M+C organization must, at a minimum, provide or arrange for the Medicare-covered benefits described in §422.101(a).

- (2) Reasonable access. The M+C organization must ensure reasonable access in the continuation area—
- (i) Through contracts with providers, or through direct payment of claims that satisfy the requirements in \$422.100(b)(2), to other providers who meet the requirement in subpart E of this part; and
- (ii) By ensuring that the access requirements of § 422.112 are met.
- (3) Reasonable cost-sharing. For services furnished in the continuation area, an enrollee's cost-sharing liability is limited to—
- (i) The cost-sharing amounts required in the M+C plan's service area (in which the enrollee no longer resides) if provided by contract providers;
- (ii) The cost-sharing amounts required by the continuation area plan if provided through agreements with another M+C plan; or
- (iii) The amount for which a beneficiary would be liable under original Medicare if noncontracting providers furnish the services.
- (4) Protection of enrollee rights. An M+C organization that offers a continuation of enrollment option must convey all enrollee rights conferred under this rule, with the understanding that—
- (i) The ultimate responsibility for all appeals and grievance requirements remain with the organization that is receiving payment from HCFA; and
- (ii) Organizations that require enrollees to give advance notice of intent to use the continuation of enrollment option, must stipulate the notification process in the marketing materials.
- (e) Capitation payments. HCFA's capitation payments to all M+C organizations, for all Medicare enrollees, are based on rates established on the basis of the enrollee's permanent residence, regardless of where he or she receives services.

[63 FR 35071, June 26, 1998; 63 FR 52611, Oct. 1, 1998]

§ 422.56 Limitations on enrollment in an M+C MSA plan.

- (a) General. An individual is not eligible to elect an M+C MSA plan—
- (1) If the number of individuals enrolled in M+C MSA plans has reached 390,000;